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Tips and Tricks:

Personalizing Care Plans

Every bit of information you capture matters!

Developing a personalized care plan that is meaningful to the patient will result in better outcomes for both the resident and your facility. Today, every bit of information you capture matters! SNFs must now find a way to manage the intersection of standardized care plans and the need for personalization.

As a director of nursing, you're ultimately responsible for the effectiveness of the care plans your staff create. But how can those plans be personalized and still use standardized content?

Follow these steps to help your facility's care plans achieve the optimal balance.

Tip 1

Conduct a robust standardized assessment that captures all the resident's needs

The assessment is the beginning of a very important process in each resident's stay at your facility, so it should be done deliberately and carefully. It might take your nurses a bit longer to conduct a thorough assessment based on standards. But in the long term, a carefully compiled profile will save your staff time, by shortening the rest of the process: diagnosis, planning, intervention and evaluation.

With residents sicker than ever and arriving with more complex illnesses, a standardized assessment walks your nurses through a predicitive workflow. This ensures that everything that should be assessed is assessed for each resident. By assessing each person in a consistent way, residents end up with better experiences and outcomes.

Tip 2

Clearly identify the strengths and preferences of each resident

So often, SNFs focus interventions based on what their residents cannot do. It's easy to say that one is unable to feed herself or another needs help with his personal care. But try flipping the script, and look at the strengths and preferences of each resident. Taking this positive approach not only improves care plans with additional insights and personalization, but focuses care on empowering your residents to maintain their current abilities and leverage their stated preferences. It all leads to better care and compliance.

For example, a resident likes to have breakfast at 9:30 am, always with a cup of hot tea.

Preferences like this should be clearly articulated in the plan for all care providers to see.

Or maybe a resident needs assistance with eating, but you've seen that he's able to take the first eight bites by himself.

Perhaps a resident who has suffered a stroke needs assistance with left-handed tasks, but is still capable of using her right hand.

Tip 3

USE those strengths and preferences within interventions, to personalize each plan

These abilities and strengths must be included in the care plan, so residents don't lose them due to lack of use and they receive care when they actually need it. By distinguishing both preferences and strengths in the care plan, you can enhance your residents' abilities, and how you administer care.

Once that individual information is gathered, be sure it's incorporated into the interventions. For example, your standard goal for the female resident who likes tea is that she eats breakfast every day. So by accounting for her preferences, she consumes that meal every day because she can do it at her optimal time and have her favorite morning beverage. In the case of the resident who independently feeds himself at the beginning of meals, you want him to meet the standard of eating a certain percentage of his food. So you allow him to start eating on his own, then offer aid when he needs it.

Deeper Insight

Higher Quality Care
Fewer Readmissions

Standardized content has been the basis of evidence and standards-based care delivery for some time. In fact, you've been using standard assessment content since the MDS was introduced.

As PDPM moves us towards a new normal, standardized content is integral for several very important reasons:

- Helps optimize analysis
- Provides care insights
- Drives consistency in care
- Enables predictable outcomes

Managing quality and reducing hospital readmissions is more important than ever to SNFs. You're under significant pressure to deliver efficient, repeatable, quality care. Plus, PDPM is already leading to more discharges by day 20. With standardized comprehensive assessments that also capture strengths and preferences, your SNF can personalize standardized interventions. By making these interventions unique to each resident, you immediately improve their chances of performing independently when they return to the community.

Delivering consistent care while still addressing a resident's unique needs can be achieved using a clinical solution directly within your EHR.

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